Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Included	Target Group/Subgroup	Minimum Age	Maximum Age	
			Maximum Age Limit: Through age –	No Maximum Age Limit
○	**Aged or Disabled, or Both**			
☐	Aged (age 65 and older)			☐
☐	Disabled (Physical) (under age 65)			
☐	Disabled (Other) (under age 65)			
	Specific Aged/Disabled Subgroup			
☐	Brain Injury			☐
☐	HIV/AIDS			☐
☐	Medically Fragile			☐
☐	Technology Dependent			☐
*	**Mental Retardation or Developmental Disability, or Both**			
☐	Autism			☐
*	Developmental Disability	No minimum		*
*	Mental Retardation	No minimum		*
○	**Mental Illness**			
☐	Mental Illness (age 18 and older)			☐
☐	Serious Emotional Disturbance (under age 18)			

b. Additional Criteria. The State further specifies its target group(s) as follows:

Persons served in this waiver meeting the above criteria minimally must:

Be diagnosed with a developmental disability (IQ generally below 70 and significant adaptive behavior deficits based on the results of standardized adaptive behavior assessments, with subtest scores generally below 70).

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

*	Not applicable – There is no maximum age limit
○	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

*	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c.*
○	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.* The limit specified by the State is *(select one)*:
	○ [ ] %, a level higher than 100% of the institutional average
	○ Other *(specify)*:
○	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
○	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*
	The cost limit specified by the State is *(select one)*:
	○ The following dollar amount: $ [ ]
	The dollar amount *(select one)*:
	○ Is adjusted each year that the waiver is in effect by applying the following formula:
	○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
	○ The following percentage that is less than 100% of the institutional average: [ ] %
	○ Other – *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Persons transitioning from the Montana Developmental Center (MDC) to an HCBS waiver placement benefit from extensive transition planning. Planning team members from the community minimally include service provider staff and case management staff, although others (e.g., the DDP QIS) may also be involved. Staff on the MDC transition planning team include residential and day services staff, management staff and professional staff representing the various disciplines involved in the provision of services. Given the broad representation of persons on the transition planning team, and the use of transition placement protocols, the potential for placement problems is minimized.

In the past, service providers were expected to provide basic furnishings and cover other one-time start up costs. This relatively new CMS reimbursement option will make it a little easier for providers to address the placement needs of the person leaving the ICF-MR.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
*	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
	If the community transition service costs were projected to exceed $3,000, the transition planning team would determine which start up costs could be allocated to an approved waiver service category. In this case, a one time only grant would be issued to the provider and this grant would be coded and billed to a specific, approved waiver service category. This could include supports such as building a wheelchair ramp (environment modification) or the purchase of a specialized piece of adaptive equipment (for example, a folding wheelchair for use on community outings). The waiver is always the payer of last resort.
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	2,011
Year 2	2,011
Year 3	Current- 2,011 Amendment Request-2,100
Year 4 (renewal only)	Current- 2,011 Amendment Request-2,150
Year 5 (renewal only)	Current- 2,011 Amendment Request-2,200

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

*	The State does not limit the number of participants that it serves at any point in time during a waiver year.
○	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

*	**Not applicable**. The state does not reserve capacity.
O	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

*	The waiver is not subject to a phase-in or a phase-out schedule.
O	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

*	Waiver capacity is allocated/managed on a statewide basis.
O	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

ARMs 37.34.301 through ARM 37.34.335 apply. In addition, the Policies and Procedures for Intensive Family Education & Support Services applies to children's services. The Referral/Waiting

List Procedures Manual and the Individualized Services and Portability Guidelines apply to adult services.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
Waiver Year:			
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

*	§1634 State
○	SSI Criteria State
○	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
☐	Low income families with children as provided in §1931 of the Act		
*	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
*	Optional State supplement recipients		
☐	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	○	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
*	Medically needy		
*	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		
	Persons in the Disabled Adult Child category –42.U.S.C.1383 (c) All other mandatory and optional groups under the State Plan if the applicant meets the targeting criteria (at least 18 and meets the state definition of developmental disability according to MCA 53-20-202(3)		
Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*			
*	**No**. The State does not furnish waiver services to individuals in the special home and		

	community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
○	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*

○	All individuals in the special home and community-based waiver group under 42 CFR §435.217	
○	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:	
☐	A special income level equal to (select one):	
	○	300% of the SSI Federal Benefit Rate (FBR)
	○ %	of FBR, which is lower than 300% (42 CFR §435.236)
	○ $	which is lower than 300%
☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)	
☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)	
☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)	
☐	Aged and disabled individuals who have income at: *(select one)*	
	○	100% of FPL
	○ %	of FPL, which is lower than 100%
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:	

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

○	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
○	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.*
○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):			
○	The following standard included under the State plan *(select one)*		
	○	SSI standard	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The special income level for institutionalized persons *(select one):*	
		○	300% of the SSI Federal Benefit Rate (FBR)
		○ %	of the FBR, which is less than 300%
		○ $	which is less than 300%.
	○ %		of the Federal poverty level
	○	Other (specify):	

○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		

ii. Allowance for the spouse only (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

iii. Allowance for the family *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Other (specify):		
○	Not applicable (see instructions)		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ The following standard under 42 CFR §435.121:
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one)*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ % of the FBR, which is less than 300%
    - ○ $ which is less than 300% of the FBR
  - ○ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- ○ The following standard under 42 CFR §435.121
- ○ Optional State supplement standard
- ○ Medically needy income standard
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The amount is determined using the following formula:
- ○ Not applicable *(see instructions)*

iii. Allowance for the family *(select one)*

- ○ AFDC need standard
- ○ Medically needy income standard

○	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one):*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ ____ % of the FBR, which is less than 300%
    - ○ $ ____ which is less than 300%.
  - ○ ____ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- ○ The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

  Specify the amount of the allowance:
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
  - ○ The amount is determined using the following formula:
- ○ Not applicable

iii. Allowance for the family *(select one)*:

○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ ____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one)*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR

○	%	of the Federal poverty level	
○	Other (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		

ii. Allowance for the spouse only (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
	○	The following standard under 42 CFR §435.121:	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount:	$	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
○	Not applicable		

iii. Allowance for the family *(select one)*

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Other (specify):		

○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**

○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
○	The special income level for institutionalized persons		
○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:		
○	Other (*specify*)**:**		

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*

○	Allowance is the same
○	Allowance is different. Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:

a. Health insurance premiums, deductibles and co-insurance charges.

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

O	The State does not establish reasonable limits.
O	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):*	
	1	
ii.	**Frequency of services**. The State requires *(select one)*:	
	*	The provision of waiver services at least monthly
	○	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○	Directly by the Medicaid agency
○	By the operating agency specified in Appendix A
*	By an entity under contract with the Medicaid agency. *Specify the entity*:
	The Medicaid agency and RNs under the Foundation contract perform the LOC evaluations and re-evaluations. Participation of the RN in the re-evaluations may be waived at the discretion of the QIS.
○	Other (*specify*):

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Quality Improvement Specialist (QIS): The DDP QIS is responsible for completing the LOC evaluations, and scheduling a Foundation nurse to participate in the initial LOC evaluation. The QIS must possess the following qualifications:

BA in psychology or social services with an emphasis in applied behavior analysis or a BA degree. Three to five years of progressively responsible programmatic experience, at least one of which must

have been in the application of the principles of applied behavior analysis to individuals with developmental disabilities. Prefer one year experience teaching the principles of applied behavior analysis.

Mountain Pacific Quality Heath Foundation (AKA Foundation) Registered Nurse (RN): The RN is responsible for completing the medical portion at the initial LOC evaluation. The RN, under contract with the Foundation, is currently licensed to practice nursing in the State of Montana.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

*Person has a developmental disability, as documented on the appropriate Waiver-3 form (3A,3R,3S, 3C) in accordance with 53-20-202(3) MCA. Standardized IQ test scores and adaptive behavior scores are required for persons aged six.
*Person has specialized services needs, documented on the applicable specialized services needs form (Medicaid Home and Community Based Services Intensive Services Level of Care Determination Summary Sheet, or, the Determination of Need for Specialized Services). Broadly, need is based on significant deficits in adaptive behaviors, significant behavior problems, or significant medical/health related issues. Medical status is reviewed by an RN and the QIS, and findings are documented on the Waiver 1 Medical Needs Summary form and the Long Term Care Patient Evaluation Abstract (LTCPEA) form.

*Person, in the absence of the waiver, is at risk of placement in a more restrictive setting such as a nursing home or an ICF-MR.

Various assessments are used to assist the QIS in completing the LOC forms, depending on the age of the recipient and his or her unique specialized services needs. The Foundation nurse and the QIS conduct a face-to-face visit with the recipient and primary care giver in the initial LOC evaluation.

All adults, inclusive of 16 years of age and older, will be determined DD by the QIS in accordance with the requirements specified in the Adult Clinical Decision Making Worksheet. Child and Family providers use the Children's Clinical Decision Making Worksheet for children up to the age of 16, or a similar document serving to verify cognitive development and adaptive behavior scores.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

○	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
*	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

	The statutory criteria for commitment to the ICF-MR is at Part 1 of Title 53, Chaper 20, MCA. The tool used by the Residential Facility Screening Team in the ICF-MR commitment process is the Determination Regarding Commitment to Residential Facility form. The governing policy for this form is the Policy For Commitment Process, Residential Facility Screening Team Determinations, effective January 2004. ICF-MR commitment is based on a person having: *A diagnosis of developmental disability. *Impairment in cognitive functioning. *Behaviors that pose an imminent risk of serious harm to self or others, or self-help deficits so severe as to require total care, and because of those behaviors or deficits cannot safely or effectively be habilitated in community-based services. *Placement and habilitation in the ICF-MR are appropriate for the person. The ICF-MR commitment criteria are somewhat different than the criteria used to determine eligibility for DD waiver services. The significant difference is the "imminent risk" of serious harm applicable to persons committed to the ICF-MR. The state statute defining developmental disability is the same for the ICF-MR and the DD waiver.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The initial LOC evaluation is scheduled at the point of entry. The child or adult has already been found DD eligible and in need of services, in accordance with applicable rules and policies governing placement on the DDP DD waiting lists. The LOC process serves to verify eligibility, need for services, other handicapping conditions and service needs, and medical issues as identified by the RN after visiting with a primary care giver.

Annual re-evaluations- The participation of a Foundation RN for the medical review section (W-1 form and the LTCPEA) may be waived at the discretion of the QIS, based on the medical status and needs of the enrolled waiver recipient.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

O	Every three months
O	Every six months
*	Every twelve months
O	Other schedule (*specify*):

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

*	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

○	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

The DDP QIS may employ various methods to ensure that evaluations occur annually. One practice is to complete the first re-evaluation in less than 12 months for the purpose of grouping the entire QIS caseload in the same month for all re-evaluations. Another practice is to complete the initial re-evaluation in less than 12 months, eventually enabling the grouping of re-evaluation dates into the same month for all the waiver recipients served by a specific provider. These practices reduce the potential for staff error in completing annual re-determinations in a timely manner. These practices also enable the efficient use of staff resources in the event travel is necessary.

The DDP Waiver Specialist position will annually review a sample of five client files for every QIS to ensure that initial and ongoing LOC reviews meet the requirements. This review process will be implemented on 7/1/06. Annual data summary results will be made available to CMS upon request.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All LOC documentation is maintained in the QIS regional or satellite office. In addition, the eligibility documentation for all adults (consisting of the QIS eligibility outcome notification letter and the Clinical Decision Making Worksheet) is maintained in the DDP central office for ease of retrieval during eligibility audits. DD eligibility documentation for children is maintained in the in the offices of the Child and Family service provider agencies.

Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Waiver-5 Freedom of Choice form is completed either prior to, or at, the annual planning meeting. The assigned case manager is responsible for ensuring a copy of the W-5 form is forwarded to the DDP QIS for inclusion in the individual client waiver files.

The QIS remains responsible for completing the W-5 during the initial face-to-face LOC evaluation, upon entry into the waiver. Adult Targeted Case Managers complete the W-5 annually thereafter for waiver recipients in adult services. Family Supports Specialists complete the forms annually thereafter for children served in the waiver.

The Explanation of ICF/MR Services and Fair Hearing Rights form provides the recipient and others with more detail and resource links for more information, in support of the W-5 form. The fair hearing rules (ARM 37.5.301 through 37.5.313) are available to recipients upon request, or can be accessed via the Department website. A web link access sheet Helpful Website Addresses for DPP Waiver Related Information is available as a resource to persons completing the W-5 form.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Written copies of these forms are available upon request from the DDP QIS regional or satellite offices. These documents are stored in the individual client waiver files, maintained by the QIS.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The Department operates under the Interpreter Services Medicaid Services Bureau policy. The interpreter is reimbursed by submitting the Interpreter Services Invoice Verification form to:

DPHHS
Medicaid Services Bureau Interpreter Services
PO Box 202951
Helena, MT 59620